		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044479

Facility Name: CENTURY VILLAGE

Address: 8540 S. HARLEM AVE. (Number) BRIDGEVIEW (City) 60455 (Zip Code)

County: COOK

Telephone Number: (708) 598-2605 **Fax #** (708) 598-5670

IDPA ID Number: 36-4300403

Date of Initial License for Current Owners: 10/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) LEO FEIGENBAUM
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	404	Skilled (SNF)	404	147,460	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	404	TOTALS	404	147,460	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,449	910	6,395	25,754	8
9	SNF/PED					9
10	ICF	73,796	2,125	1,137	77,058	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	92,245	3,035	7,532	102,812	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.72%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 48 and days of care provided 5,258

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	369,891	38,197		408,088		408,088		408,088			1
2	Food Purchase		415,932		415,932		415,932	(1,766)	414,166			2
3	Housekeeping	294,133	50,793		344,926		344,926		344,926			3
4	Laundry	114,823	54,878	285	169,986		169,986		169,986			4
5	Heat and Other Utilities			238,771	238,771		238,771		238,771			5
6	Maintenance	153,560	50,112	52,965	256,637		256,637	(3,810)	252,827			6
7	Other (specify):*			101,049	101,049		101,049		101,049			7
8	TOTAL General Services	932,407	609,912	393,070	1,935,389		1,935,389	(5,576)	1,929,813			8
	B. Health Care and Programs											
9	Medical Director			2,000	2,000		2,000		2,000			9
10	Nursing and Medical Records	2,829,706	177,834	14,270	3,021,810		3,021,810		3,021,810			10
10a	Therapy	80,261	2,909	2,102	85,272		85,272		85,272			10a
11	Activities	197,177	35,875	8,262	241,314		241,314		241,314			11
12	Social Services	135,259		660	135,919		135,919		135,919			12
13	Nurse Aide Training											13
14	Program Transportation			3,627	3,627		3,627		3,627			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,242,403	216,618	30,921	3,489,942		3,489,942		3,489,942			16
	C. General Administration											
17	Administrative	92,518		145,000	237,518		237,518	45,763	283,281			17
18	Directors Fees											18
19	Professional Services			118,598	118,598		118,598	(875)	117,723			19
20	Dues, Fees, Subscriptions & Promotions			26,664	26,664		26,664	(18,213)	8,451			20
21	Clerical & General Office Expenses	169,221	30,585	297,676	497,482		497,482	(126,261)	371,221			21
22	Employee Benefits & Payroll Taxes			695,218	695,218		695,218		695,218			22
23	Inservice Training & Education			2,763	2,763		2,763	(1,309)	1,454			23
24	Travel and Seminar			239	239		239		239			24
25	Other Admin. Staff Transportation			6,407	6,407		6,407	(1,245)	5,162			25
26	Insurance-Prop.Liab.Malpractice			315,942	315,942		315,942	2,348	318,290			26
27	Other (specify):*			116,224	116,224		116,224	(60,978)	55,246			27
28	TOTAL General Administration	261,739	30,585	1,724,731	2,017,055		2,017,055	(160,770)	1,856,285			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,436,549	857,115	2,148,722	7,442,386		7,442,386	(166,346)	7,276,040			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: CENTURY VILLAGE **#0044479** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	0	
	REPAIRS & MAINTENANCE		0	
			0	0
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		285	
			0	285
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		92,484	
	ELECTRICITY		90,581	
	WATER		55,560	
	CABLE TV - LOBBY		146	
			0	238,771
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,230	
	PAINTING & DECORATING		6,600	
	BUILDING REPAIRS		5,011	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		17,724	
	ELEVATOR MAINTENANCE & REPAIR		12,838	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		7,880	
	FIRE SERVICE		1,682	
			0	
			0	
			0	52,965
7	**OTHER**			
	SCAVENGER		24,553	
	SECURITY SERVICE		76,496	101,049
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	2,000	2,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		3,070	
	PURCHASED SERVICES		8,311	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	2,424	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	465	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	14,270
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		(1,868)	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	3,970	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	2,102
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	8,262	
			0	8,262
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	660	
			0	660
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CENTURY VILLAGE **#0044479** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		3,627	3,627
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	145,000	145,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	12,749	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	105,849	
			0	118,598
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	17,673	
	EMPLOYEE WANT ADS	XIX F	4,291	
	CONTRIBUTIONS	VI 20 XIX F	750	
	DUES & SUBSCRIPTIONS	XIX F	0	
	LICENSES & PERMITS	XIX F	2,639	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,311	26,664
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		25,489	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		214,900	
	PENALTIES / OVERDRAFT CHARGES	VI 18	11,240	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		46,047	
	MESSENGER SERVICE		0	
			0	297,676

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	334,803	
	UNEMPLOYMENT COMPENSATION	XIX D	82,450	
	WORKERS COMPENSATION INSURANCI	XIX D	106,662	
	HOSPITALIZATION INSURANCE	XIX D	169,975	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,328	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	695,218
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,763	2,763
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	239	
			0	
			0	239
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		6,407	6,407
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		315,942	315,942
27	**OTHER**			
	BAD DEBTS	VI 24	116,224	
			0	116,224

GRAND TOTAL COLUMN 3 OTHER 2,148,722

Facility Name & ID Number CENTURY VILLAGE #0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			123,336	123,336		123,336	(27,714)	95,622			30
31	Amortization of Pre-Op. & Org.			7,218	7,218		7,218		7,218			31
32	Interest			164,967	164,967		164,967	(73)	164,894			32
33	Real Estate Taxes			413,468	413,468		413,468		413,468			33
34	Rent-Facility & Grounds			1,916,980	1,916,980		1,916,980	6,330	1,923,310			34
35	Rent-Equipment & Vehicles			29,587	29,587		29,587		29,587			35
36	Other (specify):* **software amort**			11,094	11,094		11,094		11,094			36
37	**TOTAL Ownership**			2,666,650	2,666,650		2,666,650	(21,457)	2,645,193			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		51,616	444,320	495,936		495,936		495,936			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			221,190	221,190		221,190		221,190			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		51,616	665,510	717,126		717,126		717,126			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,436,549	908,731	5,480,882	10,826,162		10,826,162	(187,803)	10,638,359			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(27,714)	30		9
10	Interest and Other Investment Income	(73)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,766)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,976)	25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(11,240)	21		18
19	Entertainment		20		19
20	Contributions	(750)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,975)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(116,224)	27		24
25	Fund Raising, Advertising and Promotional	(17,673)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(30,608)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (210,999)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	23,196		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 23,196		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (187,803)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

CENTURY VILLAGE

ID# 0044479

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (3,810)	6	1
2	BANK CHARGES	(25,489)	21	2
3	ED & SEMINAR OUT OF STATE	(1,309)	23	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(30,608)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,766)	0	0	0	0	0	0	0	0	0	0	(1,766)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,810)	0	0	0	0	0	0	0	0	0	0	(3,810)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,576)	0	0	0	0	0	0	0	0	0	0	(5,576)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	45,763	0	0	0	0	0	0	0	0	0	45,763	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,975)	1,100	0	0	0	0	0	0	0	0	0	(875)	19
20	Fees, Subscriptions & Promotions	(18,423)	210	0	0	0	0	0	0	0	0	0	(18,213)	20
21	Clerical & General Office Expenses	(36,729)	(89,532)	0	0	0	0	0	0	0	0	0	(126,261)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	(1,309)	0	0	0	0	0	0	0	0	0	0	(1,309)	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(2,976)	1,731	0	0	0	0	0	0	0	0	0	(1,245)	25
26	Insurance-Prop.Liab.Malpractice	0	2,348	0	0	0	0	0	0	0	0	0	2,348	26
27	Other (specify):*	(116,224)	55,246	0	0	0	0	0	0	0	0	0	(60,978)	27
28	**TOTAL General Administration**	(177,636)	16,866	0	0	0	0	0	0	0	0	0	(160,770)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(183,212)	16,866	0	0	0	0	0	0	0	0	0	(166,346)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CENTURY VILLAGE # 0044479 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(27,714)	0	0	0	0	0	0	0	0	0	0	(27,714)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(73)	0	0	0	0	0	0	0	0	0	0	(73)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	6,330	0	0	0	0	0	0	0	0	0	6,330	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(27,787)	6,330	0	0	0	0	0	0	0	0	0	(21,457)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(210,999)	23,196	0	0	0	0	0	0	0	0	0	(187,803)	45

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				LEAF MGMT.	NILES	MANAGEMENT
SEE ATTACHED		SEE ATTACHED				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	OUTSIDE CLERICAL	$ 214,900	LEAF MANAGEMENT		$	$ (214,900)	1
2	V	21	CLERICAL SALARIES				34,607	34,607	2
3	V	17	DIRECTOR OF OPERATIONS				45,763	45,763	3
4	V	19	PROFESSIONAL FEES				1,100	1,100	4
5	V	20	DUES & SUBSCRIPTIONS				210	210	5
6	V	21	OFFICE EXPENSE				90,761	90,761	6
7	V	25	TRANSPORTATION				1,731	1,731	7
8	V	26	GENERAL INSURANCE				2,348	2,348	8
9	V	27	PAY TAX & HEALTH INS				55,246	55,246	9
10	V	34	OFFICE RENT				6,330	6,330	10
11	V								11
12	V								12
13	V								13
14	Total			$ 214,900			$ 238,096	$ * 23,196	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	LEO FEIGENBAUM	MEMBER	ADMIN.,	14.85				MGMT FEE	$ 50,000	17-3	1
2			BANKING,A/R								2
3											3
4	ELISHA ATKIN	MEMBER	ADMIN.,	14.85				MGMT FEE	50,000	17-3	4
5			BANK.,PURCH.								5
6	JOEL ATKIN	MEMBER	ADMIN.	14.85				MGMT FEE	45,000	17-3	6
7											7
8	HELEN KAPINUS	MEMBER	DIR.OF	2.48	LEAF MNGMT				45,763	17-8	8
9			OPERATIONS		SALARY-104929						9
10											10
11											11
12											12
13								TOTAL	$ 190,763		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LEAF MANAGEMENT, INC.
Street Address: 9777 GREENWOOD
City / State / Zip Code: NILES, IL 60714-1002
Phone Number: (847) 470-0000)
Fax Number: (847) 470-0061

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	CLERICAL SALARIES	DIRECT	2	1	$ 69,214	$ 69,214	1	$ 34,607	1
2	17	DIRECTOR OF OPERATIONS	PATIENT DAYS	235,733	5	104,929		102,812	45,763	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	235,733	5	2,522		102,812	1,100	3
4	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	235,733	5	482		102,812	210	4
5	21	OFFICE EXPENSE	PATIENT DAYS	235,733	5	208,102	186,794	102,812	90,761	5
6	25	TRANSPORTATION	PATIENT DAYS	235,733	5	3,968		102,812	1,731	6
7	26	GENERAL INSURANCE	PATIENT DAYS	235,733	5	5,383		102,812	2,348	7
8	27	PAY TAX & HEALTH INS	PATIENT DAYS	235,733	5	126,672		102,812	55,246	8
9	34	OFFICE RENTAL	PATIENT DAYS	235,733	5	14,514		102,812	6,330	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 535,786	$ 256,008		$ 238,096	25

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	1ST EQUITY		X	TERM LOAN	INTEREST	05/30/02	$ 258,181	$ 84,621		VAR	$ 21,438	1
2	MEMBERS LOAN	X		WORKING CAPITAL	INTEREST	10/01/99	436,000	60,000	DEMAND	8.0000	8,267	2
3												3
4												4
5												5
	Working Capital											
6	BANK ONE		X	LINE OF CREDIT	INTEREST	04/10/00				REVOLV	83,218	6
7	PREMIER BANK		X	LINE OF CREDIT	INTEREST	09/12/03	1,478,933	1,478,933		VAR	50,526	7
8				INSURANCE POLICY							1,518	8
9	TOTAL Facility Related						$ 2,173,114	$ 1,623,554			$ 164,967	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,173,114	$ 1,623,554			$ 164,967	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	449,436	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	431,452	2
3. Under or (over) accrual (line 2 minus line 1).	$	(17,984)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	431,452	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	413,468	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999	424,280	9
2000	441,346	10
2001	449,435	11
2002	431,452	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CENTURY VILLAGE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044479

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-36-403-013-0000	NURSING HOME	$ 431,452.16	$ 431,452.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 431,452.16	$ 431,452.16

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 112,340 B. General Construction Type: Exterior BRICK Frame CONCRETE/STEEL Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 36,092
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 7,218
4. Dates Incurred: 10/01/99

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VINYL FLOOR TILE			2000	13,405	487	27.5	487		1,826	9
10	HAND RAILLS / BUMPER GUARDS			2000	24,298	883	27.5	883		3,312	10
11	DRAPES WITH HARDWARE			2000	17,042	1,963	5	3,408	1,445	15,677	11
12	FLOORING POWER BOND CARPET			2000	22,676	2,612	5	4,535	1,923	20,861	12
13	WALLPAPER & PAINTING			2000	50,637	6,324	7	7,234	910	34,105	13
14	HOT WATER STORAGE TANKS & PLUMBING			2000	9,933	361	27.5	361		1,455	14
15	OVERBED LIGHT FIXTURES			2000	7,754	282	27.5	282		987	15
16	CEILING TILES			2000	4,785	174	27.5	174		609	16
17	CUSTOM NURSES STATION / BUILT WARDROBES			2000	54,060	1,966	27.5	1,966		7,454	17
18	GALVANIZED 4 FOOT FENCE			2000	2,530	169	15	169		597	18
19	LANDSCAPE TREES			2000	6,500	433	15	433		1,510	19
20	LIGHT FIXTURES			2000	10,158	369	27.5	369		1,292	20
21	CEILING TILES			2000	1,047	38	27.5	38		133	21
22	STAIR WELL			2000	1,000	36	27.5	36		122	22
23	LIGHT FIXTURES			2000	3,601	131	27.5	131		458	23
24	OUTDOOR SIGN			2000	8,945	325	27.5	325		1,070	24
25	VINYL TILE IN DINING ROOM & CORRIDOR			2000	24,147	878	27.5	878		2,817	25
26	WALLPAPER & PAINTING / WALL REPAIR			2000	33,129	4,138	7	4,732	594	22,311	26
27	ROOF TOP A/C UNIT			2000	40,200	1,462	27.5	1,462		4,813	27
28	BASE BOARD HEATER			2000	2,521	92	27.5	92		287	28
29	FIRE ALARM SYSTEM			2000	22,375	814	27.5	814		2,747	29
30	ELECTRICAL - BREAKERS & SWITCHES			2000	4,321	157	27.5	157		478	30
31	NEW ENTRANCE / STEEL DOOR FRAME			2000	45,675	1,661	27.5	1,661		5,051	31
32	ELEVATOR DOOR FRAME PROTECTORS			2000	1,414	51	27.5	51		157	32
33	ELECTRICAL			2001	3,096	113	27.5	113		287	33
34	PT ROOM RENOVATION			2001	48,135	1,751	27.5	1,751		4,450	34
35	DOOR FRAMES			2001	29,062	1,057	27.5	1,057		2,686	35
36	ELEVATOR REHAB			2001	5,850	213	27.5	213		541	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WINDOW	2001	$ 1,375	$ 50	27.5	$ 50	$	$ 127	37
38	DIALYSIS ROOM	2001	10,713	390	27.5	390		991	38
39	DOORS	2001	5,938	216	27.5	216		549	39
40	HOLDING TANK	2001	6,200	226	27.5	226		574	40
41	A/C-HEAT VENTS	2001	16,620	605	27.5	605		1,537	41
42	FIRE ALARM	2001	2,972	108	27.5	108		275	42
43	A/C UNIT	2001	13,826	503	27.5	503		1,278	43
44	HAND RAILS	2001	14,191	516	27.5	516		1,312	44
45	WATER HEATER	2001	2,200	80	27.5	80		203	45
46	FLOORING TILE	2001	32,675	6,274	5	6,535	261	19,605	46
47	DRAPES	2001	8,830	1,695	5	1,766	71	5,298	47
48	CARPETING	2001	11,493	2,207	5	2,299	92	6,897	48
49	WALLPAPERING	2001	16,463	3,161	5	3,293	132	9,879	49
50	WALL HEATING & A/C UNITS	2002	12,600	458	27.5	458		706	50
51	WALK IN COOLER	2002	2,950	108	27.5	108		166	51
52	CEILING TILE & LIGHT FIXTURES	2002	5,465	199	27.5	199		307	52
53	ROOF	2002	6,000	218	27.5	218		336	53
54	DOORS	2002	3,515	128	27.5	128		197	54
55	WALL HEATING & A/C UNITS	2002	12,600	458	27.5	458		706	55
56	HOT WATER PUMP	2002	3,525	128	27.5	128		198	56
57	SMOKE DAMPERS	2003	1,660	33	27.5	33		33	57
58	FIRE ALARM SYSTEM	2003	31,200	615	27.5	615		615	58
59	DOOR SYSTEMS	2003	1,150	22	27.5	22		22	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 722,457	$ 47,338		$ 52,766	$ 5,428	$ 189,904	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 409,358	$ 14,193	$ 40,937	$ 26,744	10	$ 129,347	71
72	Current Year Purchases	38,387	61,165	1,919	(59,246)	10	1,919	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 447,745	$ 75,358	$ 42,856	$ (32,502)		$ 131,266	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76			1999	$ 5,249	$ 640	$	$ (640)		$ 5,249	76
77										77
78										78
79										79
80	TOTALS			$ 5,249	$ 640	$	$ (640)		$ 5,249	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,175,451	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 123,336	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 95,622	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (27,714)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 326,419	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: METROPOLITAN NURSING CENTER REAL ESTATE LTTD PARTNERSHIP

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		404	10/01/99	$ 1,916,980	20		3
4	Additions							4
5								5
6								6
7	TOTAL		404		$ 1,916,980 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 10/01/99
Ending 09/30/04

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$ 2,445,993
13.	/2005	$ 2,497,604
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 23,488 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$ 6,099	17
18					18
19					19
20					20
21	TOTAL		$	$ 6,099	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number CENTURY VILLAGE | STATE OF ILLINOIS # 0044479 | Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 139,040	$		$ 139,040	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,663			3,663	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			301,617			301,617	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				12,777		12,777	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MED SUPPLIES Other (specify): IV therapy	39-8 39-8					27,889 10,950		27,889 10,950	13
14	TOTAL			$		$ 444,320	$ 51,616		$ 495,936	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 42,709	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,744,190		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	261,153		6
7	Other Prepaid Expenses	587		7
8	Accounts Receivable (owners or related parties)	358,042		8
9	Other(specify): Real Estate Escrow	431,324		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,838,005	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	529,513		15
16	Equipment, at Historical Cost	716,202		16
17	Accumulated Depreciation (book methods)	(603,270)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	809		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	4,606		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Due from CRH Property			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 647,860	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,485,865	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,289,771	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,563,554		29
30	Accrued Salaries Payable	329,105		30
31	Accrued Taxes Payable (excluding real estate taxes)	35,318		31
32	Accrued Real Estate Taxes(Sch.IX-B)	431,452		32
33	Accrued Interest Payable	12,838		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Due from CRH Properties	10,814		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,672,852	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	467,141		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 467,141	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,139,993	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (654,128)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,485,865	$	48

*(See instructions.)

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (683,799)	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (683,797)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	29,669	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 29,669	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (654,128)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,403,739	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,403,739	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	425,563	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 425,563	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	73	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 73	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ADJ PRIOR YEAR EXPENSES	26,456	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 26,456	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,855,831	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,935,389	31
32	Health Care	3,489,942	32
33	General Administration	2,017,055	33
	B. Capital Expense		
34	Ownership	2,666,650	34
	C. Ancillary Expense		
35	Special Cost Centers	495,936	35
36	Provider Participation Fee	221,190	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,826,162	40
41	**Income before Income Taxes (line 30 minus line 40)****	29,669	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 29,669	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN NOT COMPLETE AS OF COST REPORT FILING

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,003	2,264	$ 87,625	$ 38.70	1
2	Assistant Director of Nursing	922	980	28,857	29.45	2
3	Registered Nurses	13,962	15,229	383,298	25.17	3
4	Licensed Practical Nurses	45,226	48,185	1,045,567	21.70	4
5	Nurse Aides & Orderlies	101,795	107,137	1,030,259	9.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,751	6,455	80,261	12.43	8
9	Activity Director	1,931	2,076	31,804	15.32	9
10	Activity Assistants	15,644	17,837	165,373	9.27	10
11	Social Service Workers	9,692	10,803	135,259	12.52	11
12	Dietician					12
13	Food Service Supervisor	2,004	2,260	44,495	19.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	38,186	41,240	325,396	7.89	15
16	Dishwashers					16
17	Maintenance Workers	14,199	15,007	153,560	10.23	17
18	Housekeepers	38,751	41,842	294,133	7.03	18
19	Laundry	14,122	15,345	114,823	7.48	19
20	Administrator					20
21	Assistant Administrator	4,262	4,572	92,518	20.24	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,009	12,825	169,221	13.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) nrsg clerical	13,973	14,895	254,100	17.06	33
34	TOTAL (lines 1 - 33)	334,432	358,952	$ 4,436,549 *	$ 12.36	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 0	1-3	35
36	Medical Director	O	2,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,424	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		3,970	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	8,262	11-3	44
45	Social Service Consultant	E	660	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 17,316		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DAVID CHEPLOWITZ	ADMIN	0	$ 43,042
BRENDA DAVIS	ASST. ADMIN	0	44,676
KIM BRINES	ASST. ADMIN	0	4,800
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,518

B. Administrative - Other

Description	Amount
JOEL ATKIN	$ 45,000
ELISHA ATKIN	50,000
LEO FEIGENBAUM	50,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 145,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		118,598
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 118,598

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 106,662
Unemployment Compensation Insurance		82,450
FICA Taxes		334,803
Employee Health Insurance		169,975
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		1,328
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	4,291
Health Care Worker Background Check	1,311
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	17,673
TRUST/FRANCHISE/CONTRIB/ETC	750
LICENSES & PERMITS	2,439
DUES & SUBSCRIPTIONS	0
MGMT CO ALLOCATION	210
TRUST/FRANCHISE/CONTRIB/ETC	(750)
Less: Public Relations Expense	(0)
Non-allowable advertising	(17,673)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,451

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	239
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 239

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATIN	2001	$ 5,071	3 YRS	$	$ 846	$ 1,690	$ 1,690	$ 845	$	$	$	$
2	PAINTING/DECORATIN	2003	6,600	3 YRS				1,100	2,200	2,200	1,100		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 11,671		$	$ 846	$ 1,690	$ 2,790	$ 3,045	$ 2,200	$ 1,100	$	$

Facility Name & ID Number CENTURY VILLAGE # 0044479 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **221,190**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees